

CHAPTER 26.1-17.1
PREPAID LIMITED HEALTH SERVICE ORGANIZATIONS

26.1-17.1-01. Definitions. As used in this chapter, unless otherwise defined in this chapter:

1. "Enrollee" means an individual, including dependents, who is entitled to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this chapter.
2. "Evidence of coverage" means the certificate, agreement, or contract issued pursuant to section 26.1-17.1-08 setting forth the coverage to which an enrollee is entitled.
3. "Limited health service" means dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, podiatric care services, and such other services as may be determined by the commissioner to be limited health services. Limited health service may not include hospital, medical, surgical, or emergency services except as such services are provided incident to the limited health services set forth in the preceding sentence.
4. "Net equity" means the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner.
5. "Prepaid limited health service organization" means any corporation, partnership, or other entity which, in return for a prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees. Prepaid limited health service organization does not include:
 - a. An entity otherwise authorized pursuant to the laws of this state either to provide any limited health service on a prepayment or other basis or to indemnify for any limited health service;
 - b. An entity that meets the requirements of section 26.1-17.1-06; or
 - c. A provider or entity when providing or arranging for the provision of limited health services pursuant to a contract with a prepaid limited health service organization or with an entity described in subdivision a or b.
6. "Provider" means any physician, dentist, health facility, or other person or institution which is duly licensed or otherwise authorized to deliver or furnish limited health services.
7. "Subscriber" means the person whose employment or other status, except for family dependency, is the basis for entitlement to limited health services pursuant to a contract with an entity authorized to provide or arrange for such services under this chapter.
8. "Tangible net equity" means net equity reduced by the value assigned to intangible assets including goodwill; going-concern value; organizational expense; startup costs; long-term prepayments of deferred charges; nonreturnable deposits; and obligations of officers, directors, owners, or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due.
9. "Uncovered expense" means the cost of health care services that are the obligation of a prepaid limited health services organization for which an enrollee may be liable

in the event of the insolvency of the organization and for which alternative arrangements acceptable to the commissioner have not been made to cover the costs. Costs incurred by a provider who has agreed in writing not to bill enrollees, except for permissible supplemental charges, must be considered a covered expense.

26.1-17.1-02. Certificate of authority required. A person, corporation, partnership, or other entity may not operate a prepaid limited health service organization in this state without obtaining and maintaining a certificate of authority from the commissioner pursuant to this chapter.

26.1-17.1-03. Application for certificate of authority. An application for a certificate of authority to operate a prepaid limited health service organization must be filed with the commissioner on a form prescribed by the commissioner. Such application must be verified by an officer or authorized representative of the applicant and must set forth, or be accompanied by, the following:

1. A copy of the applicant's basic organizational document, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents and all amendments to such documents.
2. A copy of all bylaws, rules and regulations, or similar documents, if any, regulating the conduct of the applicant's internal affairs.
3. A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers, and any person or entity owning or having the right to acquire ten percent or more of the voting securities of the applicant, and the partners or members in the case of a partnership or association.
4. A statement generally describing the applicant, its facilities, personnel, and the limited health service or services to be offered.
5. A copy of the form of any contract made or to be made between the applicant and any providers regarding the provision of limited health services to enrollees.
6. A copy of the form of any contract made or to be made between the applicant and any person listed in subsection 3.
7. A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any functions, including the following:
 - a. Marketing and enrollment.
 - b. Administration.
 - c. Investment management.
 - d. Subcontracting for the provision of the limited health service to enrollees.
8. A copy of the form of any contract which is to be issued to employers, unions, trustees, or other organizations or individuals and a copy of any form of evidence of coverage to be issued to subscribers or enrollees.
9. A copy of the applicant's most recent financial statements audited by independent certified public accountants. If the financial affairs of the applicant's parent company are audited by independent certified public accountants but those of the applicant

are not, then a copy of the most recent audited financial statement of the applicant's parent company, certified by an independent certified public accountant, attached to which will be consolidating financial statements of the applicant, satisfies this requirement unless the commissioner determines that additional or more recent financial information is required for the proper administration of this chapter.

10. A copy of the applicant's financial plan, including a three-year projection of anticipated operating results, a statement of the sources of working capital, and any other sources of funding and provisions for contingencies.
11. A schedule of rates and charges.
12. A description of the proposed method of marketing.
13. A statement acknowledging that all lawful process in any legal action or proceeding against the applicant on a cause of action arising in this state is valid if served upon the commissioner.
14. A description of the complaint procedures to be established and maintained as required under section 26.1-17.1-12.
15. A description of the quality assessment and utilization review procedures to be utilized by the applicant.
16. A description of how the applicant will comply with section 26.1-17.1-17.
17. The fee for issuance of a certificate of authority provided in section 26.1-17.1-23.
18. Such other information as the commissioner may reasonably require to make the determinations required by this chapter.

26.1-17.1-04. Issuance of certificate of authority - Denial.

1. Following receipt of an application filed pursuant to section 26.1-17.1-03, the commissioner shall review such application and notify the applicant of any deficiencies. The commissioner shall issue a certificate of authority to an applicant provided that the following conditions are met:
 - a. The requirements of section 26.1-17.1-03 have been fulfilled.
 - b. The individuals responsible for conducting the applicant's affairs are competent, trustworthy, and possess good reputations, and have had appropriate experience, training, or education.
 - c. The applicant is financially responsible and may reasonably be expected to meet its obligations to enrollees and to prospective enrollees. In making this determination, the commissioner may consider:
 - (1) The financial soundness of the applicant's arrangements for limited health services and the minimum standard rates, deductibles, copayments, and other patient charges used in connection therewith.
 - (2) The adequacy of working capital, other sources of funding, and provisions for contingencies.
 - (3) Any agreement for paying the cost of the limited health services or for alternative coverage in the event of insolvency of the prepaid limited health service organization.

- (4) The manner in which the requirements of section 26.1-17.1-17 have been fulfilled.
 - d. The agreements with providers for the provision of limited health services contain the provisions required by section 26.1-17.1-16.
 - e. Any deficiencies identified by the commissioner have been corrected.
2. If the certificate of authority is denied, the commissioner shall notify the applicant and shall specify the reasons for denial in the notice. The applicant has thirty days from the date of receipt of the notice to request a hearing before the commissioner pursuant to chapter 28-32.

26.1-17.1-05. Effect on organizations operating on effective date of this chapter.

Within ninety days after August 1, 1993, every prepaid limited health service organization operating in this state without a certificate of authority shall submit an application for a certificate of authority to the commissioner. Each such organization may continue to operate during the pendency of its application. In the event an application is denied under this section, the applicant will then be treated as a prepaid limited health service organization whose certificate of authority has been revoked.

26.1-17.1-06. Filing requirements for authorized entities.

1. Any entity authorized pursuant to the laws of this state to operate a health maintenance organization, an accident and health insurance company, a nonprofit health, hospital, or medical service corporation, or a fraternal benefit society and which is not otherwise authorized pursuant to the laws of this state to offer limited health services on a per capita or fixed prepayment basis may do so by filing for approval with the commissioner the information requested by subsections 4, 5, 7, 8, 10, 11, 12, and 15 of section 26.1-17.1-03 and any subsequent material modification or addition thereto.
2. Following approval by the commissioner of the filing in subsection 1, and upon application by the entity and surrender of its original certificate of authority, the commissioner may issue a new certificate of authority under this chapter. The entity will be subject to the capitalization requirements under its original certificate of authority and the net equity and deposit provisions of section 26.1-17.1-17 do not apply.
3. If the commissioner disapproves the filing, the procedures set forth in subsection 2 of section 26.1-17.1-04 must be followed.

26.1-17.1-07. Changes in rates and benefits and material modifications - Addition of limited health services.

1. A prepaid limited health service organization shall file with the commissioner, prior to use, a notice of any change in rates, charges, or benefits and of any material modification of any matter or document furnished pursuant to section 26.1-17.1-03, together with such supporting documents as are necessary to fully explain the change or modification.
2. If a prepaid limited health service organization desires to add one or more limited health services, it shall file a notice with the commissioner and, at the same time, shall submit the information required by section 26.1-17.1-03 and shall demonstrate compliance with sections 26.1-17.1-16, 26.1-17.1-17, and 26.1-17.1-23.
3. A change or modification filed with the commissioner pursuant to subsections 1 and 2 may be used by the prepaid limited health service organization only after approval by the commissioner or upon the expiration of sixty days from the date of filing.

4. If such filings are disapproved, the commissioner shall notify the prepaid limited health service organization and shall specify the reasons for disapproval in the notice. The prepaid limited health service organization has thirty days from the date of receipt of notice to request a hearing before the commissioner pursuant to chapter 28-32.

26.1-17.1-08. Evidence of coverage.

1. Every subscriber must be issued an evidence of coverage, which must contain a clear and complete statement of:
 - a. The limited health services to which each enrollee is entitled.
 - b. Any limitation of the services, kinds of services or benefits to be provided, and exclusions, including any deductible, copayment, or other charges.
 - c. Where and in what manner information is available as to where and how services may be obtained.
 - d. The method for resolving complaints.
2. Any amendment to the evidence of coverage may be provided to the subscriber in a separate document.

26.1-17.1-09. Rates and charges. The rates and charges must be reasonable in relation to the services provided. The commissioner may request information from the prepaid limited health service organization supporting the appropriateness of the rates and charges.

26.1-17.1-10. Construction with other laws.

1.
 - a. A prepaid limited health service organization organized under the laws of this state must be deemed to be a domestic insurer for purposes of chapter 26.1-10 unless specifically exempted in writing from one or more of the provisions of such act by the commissioner.
 - b. A prepaid limited health service organization is subject to chapter 26.1-04.
 - c. No other provision of the insurance code applies to a prepaid limited health service organization unless such an organization is specifically mentioned therein, or unless otherwise provided in this chapter.
2. The provision of limited health services by a prepaid limited health service organization or other entity pursuant to this chapter may not be deemed to be the practice of medicine or other healing arts.
3. Solicitation to arrange for or provide limited health services in accordance with this chapter may not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

26.1-17.1-11. Nonduplication of coverage. Notwithstanding any other law of this state, a prepaid limited health service organization, health maintenance organization, accident and health insurance company, nonprofit health or hospital or medical service corporation, or fraternal benefit society may exclude, in any contract or policy issued to a group, any coverage that would duplicate the coverage for limited health services, whether in the form of services, supplies, or reimbursement, insofar as the coverage or service is provided in accordance with this chapter under a contract or policy issued to the same group or to a part of that group by a prepaid limited health service organization, a health maintenance organization, an accident and health insurance company, a nonprofit health or hospital or medical service corporation, or a fraternal benefit society.

26.1-17.1-12. Complaint system. Every prepaid limited health service organization shall establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers. Nothing herein may be construed to preclude an enrollee or a provider from filing a complaint with the commissioner or as limiting the commissioner's ability to investigate such complaints.

26.1-17.1-13. Examination of organization.

1. For purposes of examination, expenses of examination, and tax credits therefor, each prepaid limited health service organization is subject to the laws applicable to insurance companies.
2. In lieu of such examination, the commissioner may accept the report of an examination made by the commissioner of another state.

26.1-17.1-14. Investments. The funds of a prepaid limited health service organization may be invested only in accordance with the laws and rules applicable to insurance companies.

26.1-17.1-15. Insurance producers. No individual may apply, procure, negotiate, or place for others any policy or contract of a prepaid limited health service organization unless that individual holds a license or is otherwise duly authorized to sell accident and health insurance policies, health, hospital or medical service contracts, or health maintenance organization contracts.

26.1-17.1-16. Contracts with providers. All contracts with providers or with entities subcontracting for the provision of limited health services to enrollees on a prepayment or other basis must contain or must be construed to contain the following terms and conditions:

1. In the event the prepaid limited health service organization fails to pay for limited health services for any reason whatsoever, including insolvency or breach of this contract, the enrollees are not liable to the provider for any sums owed to the provider under this contract.
2. No provider, agent, trustee, or assignee thereof may maintain an action at law or attempt to collect from the enrollee sums owed to the provider by the prepaid limited health service organization.
3. These provisions do not prohibit collection of uncovered charges consented to by enrollees or collection of copayments from enrollees.
4. These provisions survive the termination of this contract, regardless of the reason giving rise to termination.
5. Termination of this contract does not release the provider from completing procedures in progress on enrollees then receiving treatment for a specific condition for a period not to exceed sixty days, at the same schedule of copayment or other applicable charge in effect upon the effective date of termination of this contract.
6. Any amendment to these foregoing provisions of this contract must be submitted to and be approved by the commissioner prior to becoming effective.

26.1-17.1-17. Protection against insolvency - Deposit.

1. a. Except as approved in accordance with subsection 3, each prepaid limited health service organization shall, at all times, have and maintain tangible net equity equal to the greater of:
 - (1) Fifty thousand dollars; or

- (2) Two percent of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.
 - b. A prepaid limited health service organization that has uncovered expenses in excess of fifty thousand dollars, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to twenty-five percent of the uncovered expense in excess of fifty thousand dollars in addition to the tangible net equity required by subdivision a of subsection 1.
- 2.
- a. Each prepaid limited health service organization shall deposit with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to the commissioner in an amount equal to twenty-five thousand dollars plus twenty-five percent of the tangible net equity required in subsection 1; provided, however, that the deposit may not be required to exceed one hundred thousand dollars.
 - b. The deposit shall be an admitted asset of the prepaid limited health service organization in the determination of tangible net equity.
 - c. All income from deposits shall be an asset of the prepaid limited health service organization. A prepaid limited health service organization may withdraw a deposit or any part thereof after making a substitute deposit of equal amount and value. Any securities must be approved by the commissioner before being substituted.
 - d. The deposit must be used to protect the interests of the prepaid limited health service organization's enrollees and to assure continuation of limited health care services to enrollees of a prepaid limited health service organization that is in rehabilitation or conservation. If a prepaid limited health service organization is placed in receivership or liquidation, the deposit shall be an asset subject to provisions of the liquidation act.
 - e. The commissioner may reduce or eliminate the deposit requirement if the prepaid limited health service organization has made an acceptable deposit with the state or jurisdiction of domicile for the protection of all enrollees, wherever located, and delivers to the commissioner a certificate to such effect, duly authenticated by the appropriate state official holding the deposit.
3. The commissioner may waive the requirements of subsections 1 and 2 upon a finding that:
- a. The prepaid limited health service organization has a net equity of at least five million dollars; or
 - b. An entity having a net equity of at least five million dollars furnishes to the commissioner a written commitment, which is acceptable to the commissioner, to provide for the uncovered expenses of the prepaid limited health service organization.

26.1-17.1-18. Officers and employees fidelity bond.

1. A prepaid limited health service organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than fifty thousand dollars or in any other amount prescribed by the commissioner. Except as otherwise provided by this subsection, the bond must be issued by an insurance company that

is licensed to do business in this state or, if the fidelity bond required by this subsection is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed surplus lines insurance producer in this state shall satisfy the requirements of this subsection.

2. In lieu of the bond specified in subsection 1, a prepaid limited health service organization may deposit with the commissioner cash or securities or other investments of the types set forth in section 26.1-17.1-14. Such a deposit must be maintained in joint custody with the commissioner in the amount and subject to the same conditions required for a bond under this subsection.

26.1-17.1-19. Reports.

1. Every prepaid limited health service organization shall file with the commissioner annually, on or before March first, a report verified by at least two principal officers covering the preceding calendar year.
2. Such report must be on forms prescribed by the commissioner and must include:
 - a. A financial statement of the organization, including its balance sheet, income statement, and statement of changes in financial position for the preceding year, certified by an independent public accountant or a consolidated audited financial statement of its parent company certified by an independent public accountant, attached to which must be consolidating financial statements of the prepaid limited health service organization.
 - b. The number of subscribers at the beginning of the year, the number of subscribers as of the end of the year, and the number of enrollments terminated during the year.
 - c. Such other information relating to the performance of the organization as is necessary to enable the commissioner to carry out the duties under this chapter.
3. The commissioner may require more frequent reports containing such information as is necessary to enable the commissioner to carry out the duties under this chapter.
4. The commissioner may assess a fine of up to one hundred dollars per day for each day any required report is late, and the commissioner may suspend the organization's certificate of authority pending the proper filing of the required report by the organization.

26.1-17.1-20. Suspension or revocation of certificate of authority.

1. The commissioner may suspend or revoke the certificate of authority issued to a prepaid limited health service organization pursuant to this chapter upon determining that any of the following conditions exist:
 - a. The prepaid limited health service organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to section 26.1-17.1-03, unless amendments to such submissions have been filed and authorized pursuant to section 26.1-17.1-07.
 - b. The prepaid limited health service organization issues an evidence of coverage or uses rates or charges which do not comply with the requirements of sections 26.1-17.1-08 and 26.1-17.1-09.

- c. The prepaid limited health service organization is unable to fulfill its obligations to furnish limited health services.
 - d. The prepaid limited health service organization is not financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.
 - e. The tangible net equity of the prepaid limited health service organization is less than that required by section 26.1-17.1-17 or the prepaid limited health service organization has failed to correct any deficiency in its tangible net equity as required by the commissioner.
 - f. The prepaid limited health service organization has failed to implement in a reasonable manner the complaint system required by section 26.1-17.1-12.
 - g. The continued operation of the prepaid limited health service organization would be hazardous to its enrollees.
 - h. The prepaid limited health service organization has otherwise failed to comply with this chapter.
2. If the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, the commissioner shall notify the prepaid limited health service organization in writing specifically stating the grounds for suspension or revocation and fixing a time not more than sixty days thereafter for a hearing on the matter in accordance with chapter 28-32.
 3. When the certificate of authority of a prepaid limited health service organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as the commissioner may find to be in the best interest of the enrollees, to the end that the enrollees will be afforded the greatest practical opportunity to obtain continuing limited health services.

26.1-17.1-21. Penalties. In lieu of any penalty specified elsewhere in this chapter, or when no penalty is specifically provided, whenever any prepaid limited health service organization or other person, corporation, partnership, or entity subject to this chapter has been found after hearing to have violated any provision of this chapter, the commissioner may:

1. Issue and cause to be served upon the organization, person, or entity charged with the violation a copy of such findings and an order requiring such organization, person, or entity to cease and desist from engaging in the act or practice which constitutes the violation.
2. Impose a monetary penalty of not more than one thousand dollars for each violation, but not to exceed an aggregate penalty of ten thousand dollars.

26.1-17.1-22. Rehabilitation, conservation, or liquidation.

1. Any rehabilitation, conservation, or liquidation of a prepaid limited health service organization must be deemed to be the rehabilitation, conservation, or liquidation of an insurance company and must be conducted pursuant to chapter 26.1-06.1.
2. Prepaid limited health service organizations are not subject to chapter 26.1-38.1, nor do the protections provided by chapter 26.1-38.1 apply to any individuals entitled to receive limited health services from a prepaid limited health service organization.

26.1-17.1-23. Fees. Every prepaid limited health service organization is subject to the fees set out in section 26.1-01-07.

26.1-17.1-24. Confidentiality.

1. Any information pertaining to the diagnosis, treatment, or health of any enrollee obtained from such person or from any provider by any prepaid limited health service organization and any contract with providers submitted pursuant to the requirements of this chapter must be held in confidence and may not be disclosed to any person except:
 - a. To the extent that it may be necessary to carry out the purposes of this chapter;
 - b. Upon the express consent of the enrollee or applicant, provider, or prepaid limited health service organization, as appropriate;
 - c. Pursuant to statute or court order for the production of evidence or the discovery thereof; or
 - d. In the event of claim or litigation wherein such data or information is relevant.
2. With respect to any information pertaining to the diagnosis, treatment, or health of any enrollee or applicant, a prepaid limited health service organization is entitled to claim any statutory privileges against disclosure which the provider who furnished such information to the prepaid limited health service organization is entitled to claim.
3. In addition, any information provided to the commissioner that constitutes a trade secret, is privileged information, or is part of a department investigation or examination must be held in confidence.

26.1-17.1-25. Taxes. Every prepaid limited health service organization is subject to the tax provided in section 26.1-03-17 as it pertains to health maintenance organizations, and each prepaid limited health service organization is entitled to the same tax deductions, reductions, abatements, and credits that health maintenance organizations are entitled to receive.

26.1-17.1-26. Rulemaking. The commissioner may adopt reasonable rules necessary in the implementation of this chapter.